

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
6529 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

06517
282

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				d. STREET ADDRESS none				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Pauline Regina BARBER				4. DATE OF DEATH Month Day Year June 22 1956							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 23, 1887		9. AGE (In years last birthday) yrs. 69		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher				10b. KIND OF BUSINESS OR INDUSTRY State		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samual ADAMS				14. MOTHER'S MAIDEN NAME Jane A. McGregor							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Ninian P. Barber Jr. Mechanicsville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) hypertension DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH 30 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 1956 to June 1956 that I last saw the deceased alive on June 21 , 19 56 , and that death occurred at 11 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Leah B. Beube M.D. PHYSICIAN'S NAME (Type) Dr. J. Roy Guyther Mechanicsville, Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF June 25, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cem.		22d. LOCATION (City, town, or county) (State) Morganza, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Robinson				ADDRESS Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE 6/25/56		24b. REGISTRAR'S SIGNATURE Glenn A. Hauer			

CERTIFICATE OF DEATH

0359

NAME OF DECEASED JAMES A. HARRISON		DATE OF BIRTH JAN 15 1900		PLACE OF BIRTH BALTIMORE, MARYLAND	
SEX Male		AGE 56		OCCUPATION None	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PLACE OF DEATH Home	
DATE OF DEATH JUN 26 1956		TIME OF DEATH 10:00 AM		PLACE OF DEATH Home	
SIGNATURE OF PHYSICIAN J. A. Harrison		SIGNATURE OF WITNESSES J. A. Harrison		SIGNATURE OF DECEASED J. A. Harrison	

CVA
pulmonary

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JUN 26 1956

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13 June

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06518**
282

1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Leonardtown				c. LENGTH OF STAY IN 1b 3 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clements	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Augustus Leroy Berry				4. DATE OF DEATH Month Day Year June 17, 1956			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 25, 1948	
9. AGE (In years last birthday) 7 yrs.		IF UNDER 1 YEAR Months 5 Days 23		IF UNDER 24 HRS. Hours 5 Min. 23			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Agustus William Berry				14. MOTHER'S MAIDEN NAME Mary Madalene Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Agustus W. Berry Clements, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Roy Guyther				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Roy Guyther M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/56		22c. NAME OF CEMETERY OR CREMATORY St Joseph		22d. LOCATION (City, town, or county) (State) Morganza, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly				ADDRESS Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE 6/19/56	
						24b. REGISTRAR'S SIGNATURE Alfred D. Houser	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 45		SEX Male		RACE White		DATE OF DEATH June 25, 1956		PLACE OF DEATH Home	
RESIDENCE 1234 Main St., Baltimore, Md.		OCCUPATION Teacher		EDUCATION High School		MARRIAGE Married		SINGLE		WIDOWED	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial Infarction		UNDERLYING CAUSE Coronary Artery Disease		PREEXISTING DISEASES Hypertension		OTHER CAUSES None	
SIGNATURE OF EXAMINER [Signature]		DATE June 25, 1956		PLACE Baltimore, Md.		TIME 10:00 AM		HOUR 10:00		MINUTE 00	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06519

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No

282

6531

1. PLACE OF DEATH a. COUNTY St Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Leonardtown c. LENGTH OF STAY IN 1b 3 hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY St Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clements d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Christene Elane Berry				4. DATE OF DEATH Month Day Year June 17, 1956			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 11, 47	
9. AGE (In years last birthday) 8 yrs.		IF UNDER 1 YEAR Months 9 Days 8		IF UNDER 24 HRS. Hours 8 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Agustus William Berry				14. MOTHER'S MAIDEN NAME Mary Madalene Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Agustus W. Berry Clements, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Roy Guyther				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Roy Guyther M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED June 18 1956			
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF 6/20/56		22c. NAME OF CEMETERY OR CREMATORY St Joseph's		22d. LOCATION (City, town, or county) (State) Morganza, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE 6/19/56		24b. REGISTRAR'S SIGNATURE Alan D. Hauser	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Leonardtown				c. LENGTH OF STAY IN lb 3 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clements	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Madeline Middle Berry Last Berry				4. DATE OF DEATH Month June Day 17 Year 19 56			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 8, 1928	
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months 28 Days 17 Hours 19 Min. 56		IF UNDER 24 HRS. Months 28 Days 17 Hours 19 Min. 56			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Annie Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT Agustus W. Berry Clements, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE J. Roy Guyther				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) J. Roy Guyther M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED June 17, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6/20/56		22c. NAME OF CEMETERY OR CREMATORY St Joseph		22d. LOCATION (City, town, or county) (State) Morganzan Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly Leonardtown, Md.				24a. REC'D BY REGISTRAR 6/19/56		24b. REGISTRAR'S SIGNATURE Glen D. Houser	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES J. JONES		Male		35		JAN 15 1920	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1234 Main St. Baltimore, Md.		Carpenter		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE	
JUN 10 1956		Home		10:30 AM		Normal	
SIGNATURE OF EXAMINER		TITLE		DATE		TIME	
J. A. Smith		Medical Examiner		JUN 10 1956		10:30 AM	

RECEIVED
 JUN 20 1956
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6535 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY <u>St Mary's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Leonardtown</u> c. LENGTH OF STAY IN 1b <u>3 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St Mary's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Clements</u> d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last <u>Paul L. Berry</u>				4. DATE OF DEATH Month Day Year <u>June 17, 1956</u>																			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1949</u>		9. AGE (In years last birthday) <u>6</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>Agustus William Berry</u>								14. MOTHER'S MAIDEN NAME <u>Mary Madalene Thomas</u>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)				17. INFORMANT Address <u>Agustus W. Berry Clements Maryland</u>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____												INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)											
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																							
ACTUAL SIGNATURE <u>J. Roy Guyther</u> M.D.																							
EXAMINER'S NAME (Type) <u>Roy Guyther M.D.</u>																							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>														22b. DATE THEREOF <u>6/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Joseph's</u>				22d. LOCATION (City, town, or county) (State) <u>Morganza, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Mattingly Leonardtown, Md.</u>								24a. REC'D BY REGISTRAR DATE <u>6/19/56</u>		24b. REGISTRAR'S SIGNATURE <u>Glen D. Houser</u>													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, MASS.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES J. CONNOR		AGE 35		SEX Male		RACE White		DATE OF DEATH JUNE 20, 1936		PLACE OF DEATH Home	
RESIDENCE 123 Main St., Boston, Mass.		OCCUPATION Carpenter		EDUCATION High School		MARRIAGE Married		SINGLE OR MARRIED Married		DATE OF MARRIAGE JUNE 15, 1935	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial Infarction		DISEASE OR INJURY Coronary Artery Disease		PREVIOUS ILLNESS Hypertension		TREATMENT Medical	
SIGNATURE OF EXAMINER [Signature]		DATE JUNE 20, 1936		PLACE Boston, Mass.		TIME 10:00 AM		HOUR 10:00		MINUTE 00	

BUREAU V. S.

JUN 20 1936

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 39 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. MARY'S HOSPITAL		d. STREET ADDRESS MECHANICSVILLE	
3. NAME OF DECEASED (Type or print) First LYDIA Middle A. Last BOND		4. DATE OF DEATH Month JUNE Day 6 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 6 1897
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 8 Days 8 Hours 8 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK L. BOND		14. MOTHER'S MAIDEN NAME M. DAVIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT HAYDEN B. BOND, MECHANICSVILLE MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast with 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized metastases DUE TO (c) 1 yr		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1, 1956 , to June 6, 1956 , that I last saw the deceased alive on June 5, 1956 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) MECHANICSVILLE MD DATE SIGNED 6/6/56			
ACTUAL SIGNATURE ROY J. GUYTHER M.D.		PHYSICIAN'S NAME (Type) ROY J. GUYTHER M.D. MECHANICSVILLE MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/8/56	
22c. NAME OF CEMETERY OR CREMATORY London Park		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE CHARLES J. MATTINGLY		ADDRESS LEONARDTOWN MD.	
24a. REC'D BY REGISTRAR 6/7/56		24b. REGISTRAR'S SIGNATURE Almond H. Hauser	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU

1956 8 NG

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06523**
282

6535

1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Leonardtown c. LENGTH OF STAY IN 1b 3 hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY St Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clements d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Gladis Middle Virginia Last Brown				4. DATE OF DEATH Month June Day 17, Year 19 56									
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 27, 1943		9. AGE (In years last birthday) 13 yrs.		IF UNDER 1 YEAR Months 2 Days 21		IF UNDER 24 HRS. Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Mary Madalene Thomas							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT Agustus W. Berry Clements, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____ </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Roy Guyther</i>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) Roy Guyther M.D.						DATE SIGNED June 18, 1956							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/20/56		22c. NAME OF CEMETERY OR CREMATORY St Joseph's				22d. LOCATION (City, town, or county) (State) Morganza, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly						ADDRESS Leonardtown, Md.							
24a. REC'D BY REGISTRAR DATE 6/19/56						24b. REGISTRAR'S SIGNATURE <i>Glean D. Hauser</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06524
281

6536

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREAT MILLS				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RURAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HELEN Middle MIGNONETTE Last BRYANT				4. DATE OF DEATH Month JUNE Day 8 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 17, 1906	
9. AGE (In years last birthday) 49 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME GEORGE R. DEMENT			
14. MOTHER'S MAIDEN NAME ALETHA M. PRICE				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) -----			
16. SOCIAL SECURITY NO. -----				17. INFORMANT EMORY M. BRYANT - CALLAWAY, MARYLAND.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Cholecystitis				INTERVAL BETWEEN ONSET AND DEATH 1 hour			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb 28, 1956 , to June 8, 1956 , that I last saw the deceased alive on June 8, 1956 , and that death occurred at 9:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) Great Mills Md			
PHYSICIAN'S NAME (Type) [Signature]				DATE SIGNED 6/14/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/11/56		22c. NAME OF CEMETERY OR CREMATORY POPLAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) VALLEY LEE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]				ADDRESS LEONARDTOWN, Md.			
24a. REC'D BY REGISTRAR [Signature]				24b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66525

6537

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle Luther Last Burroughs				4. DATE OF DEATH Month June Day 22 Year 1956			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 30, 1864	
9. AGE (In years and birthday) 91 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME William Thomas Burroughs			
14. MOTHER'S MAIDEN NAME Mary Margaret Bond				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. NO				17. INFORMANT E. Ray Burroughs Address Mechanicsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE Leon A. Benile M.D.				PHYSICIAN'S NAME (Type) J. Roy Guyther M.D. Mechanicsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/56		22c. NAME OF CEMETERY OR CREMATORY All Faith		22d. LOCATION (City, town, or county) (State) Charlotte Hall, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE 6/25/56		24b. REGISTRAR'S SIGNATURE Alfred D. Hauer	

9561 28 JUN

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
6538
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1806526
Items 8,9/FilmG108 6-18-56 et
CERTIFICATE OF DEATH
Reg. Dist. No. 281

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGE				c. LENGTH OF STAY IN 1b 29 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS ST. INIGOES			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM THOMAS COULTER				4. DATE OF DEATH Month Day Year JUNE 12 19 56			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1867 AUG. 22 1863/88/92	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 10 10		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER				10b. KIND OF BUSINESS OR INDUSTRY PLUMBING		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ANDREW COULTER				14. MOTHER'S MAIDEN NAME SARAH M. McDONALD McDonald			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT STANLEY RALEY				Address ST. INIGOES MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 years 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 10, 1956 , to June 12, 1956 , that I last saw the deceased alive on June 9, 1956 , and that death occurred at 4 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) GREAT MILLS MARYLAND DATE SIGNED 6/13/56 ACTUAL SIGNATURE P. J. BEAN M.D. PHYSICIAN'S NAME (Type) P. J. BEAN M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/16/1956		22c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL		22d. LOCATION (City, town, or county) (State) RIDGE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE CHARLES J. MATTINGLY				ADDRESS LEONARDTOWN MD.		24a. REC'D BY REGISTRAR DATE 6/13/56	
24b. REGISTRAR'S SIGNATURE P. J. Bean							

JUN 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07569

6539

CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH a. COUNTY <u>ST MARY'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ST MARY'S</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LEONARDTOWN</u>				c. LENGTH OF STAY IN 1b <u>2 HRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ST MARY'S HOSPITAL</u>				d. STREET ADDRESS <u>BAKVILLE</u>			
3. NAME OF DECEASED (Type or print) <u>NEWBORN BABY</u> First <u>BABY</u> Middle <u>FORD</u> Last				4. DATE OF DEATH Month <u>JUNE</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 23 '56</u>		9. AGE (In years last birthday) <u>2 HRS</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>2</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ALOYSIUS DICKERSON</u>				14. MOTHER'S MAIDEN NAME <u>BARBARA ANN FORD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MOTHER</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UNKNOWN - POSSIBLY ASPHYXIA</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO MUCOUS</u> DUE TO (c) <u>2 HRS</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PREMATURITY</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 23, 1956</u> , to <u>June 23, 1956</u> , that I last saw the deceased alive on <u>June 23, 1956</u> , and that death occurred at <u>9 1/2 M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Roy Guyther</u> M.D.				ADDRESS (Street, city or town, state) <u>Mechanicville Md</u> DATE SIGNED <u>7/1/56</u>			
PHYSICIAN'S NAME (Type) <u>J. Roy Guyther, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>				<u>St Aloysius</u>		<u>Leonardtown, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Whitake Mattingly</u>				ADDRESS <u>Leonardtown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7/16/56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Glean D. Houser</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6540
CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b SCOTLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. MARYS HOSPITAL		d. STREET ADDRESS RURAL	
3. NAME OF DECEASED (Type or print) First MARY Middle PEARL Last GIBSON		4. DATE OF DEATH Month JUNE Day 17 Year 1956	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1888
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jack Bennett		14. MOTHER'S MAIDEN NAME Anna Brooks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Alexander Cullison - Scotland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arterio-sclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 91 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1, 1950 , to June 17, 1956 , that I last saw the deceased alive on June 16, 1956 , and that death occurred at 3 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE P. J. BEAN		ADDRESS (Street, city or town, state) GREAT MILLS, MARYLAND	
DATE SIGNED 6/15/56			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-20-56	
22c. NAME OF CEMETERY OR CREMATORY ST. LUKES CEMETERY		22d. LOCATION (City, town, or county) (State) SCOTLAND, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Robinson		ADDRESS LEONARDTOWN, Md.	
24a. REC'D BY REGISTRAR DATE 6/18/56		24b. REGISTRAR'S SIGNATURE Local Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06528

6541

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SCOTLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. MARYS HOSPITAL				d. STREET ADDRESS RURAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First REAVA Middle IRENE Last GOUGH		4. DATE OF DEATH Month JUNE Day 3 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 JAN. 1928		9. AGE (In years last birthday) 28 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CALVERT BARNES				14. MOTHER'S MAIDEN NAME INEZ BISCOE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-24-3878		17. INFORMANT ROBERT GOUGH - SCOTLAND, MARYLAND.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2nd vent & 3rd degree burns of arms, legs 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) and body DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 45 hours							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) There was a fire which burned onto her clothing			
20c. TIME OF INJURY Hour a. m. 4 p. m. June 1, 1956		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Scotland (County) St. Marys (State) MD	
21. I certify that I attended the deceased from June 1, 1956 , to June 3, 1956 , that I last saw the deceased alive on June 3, 1956 , and that death occurred at 8 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Great Mills, Maryland. DATE SIGNED June 4/56							
ACTUAL SIGNATURE P. J. Bean		M.D.					
PHYSICIAN'S NAME (Type) P. J. BEAN, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/6/56		22c. NAME OF CEMETERY OR CREMATORY ST. LUKES CEMETERY		22d. LOCATION (City, town, or county) (State) SCOTLAND, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Robinson				ADDRESS * LEONARDTOWN, Md.		24a. REC'D BY REGISTRAR DATE June 4/56	
				24b. REGISTRAR'S SIGNATURE [Signature]			

RECEIVED

9561 9 JUN

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 8, (See birth Cert.)
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) First James Middle Edward Last GRAVES		4. DATE OF DEATH Month June Day 24 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1916 23 June 1913
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile	9. AGE (In years last birthday) 40 yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis B. GRAVES		14. MOTHER'S MAIDEN NAME Eva McGINLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1934 - 1936		16. SOCIAL SECURITY NO. 1934 - 1936	
17. INFORMANT Louis B. GRAVES Jr.		Address Leonardtwn, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) malnutrition, chronic alcoholism 322.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) hyperpyrexia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 23, 1916 to June 23, 1916 that I last saw the deceased alive on June 23, 1916 , and that death occurred at 12 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Leonardtwn, Maryland 6.25.16 ACTUAL SIGNATURE Dr. M. Barbarich M.D. Leonardtwn, Maryland PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 27, 1956	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Robinson		ADDRESS Leonardtwn, Md.	24a. REC'D BY REGISTRAR DATE 6/25/56
		24b. REGISTRAR'S SIGNATURE Clara P. Hayer	

JUN 26 1956

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BUREAU A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06530

182

1. PLACE OF DEATH o. COUNTY St Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY St Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mechanicsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mechanicsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Robert Theodore Herbert		4. DATE OF DEATH Month June Day 10 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 7, 1879
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 8 Days 3 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Benjamin Herbert	
14. MOTHER'S MAIDEN NAME Elizabeth Dean		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mary Ozema Herbert Address Mechanicsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DEGENERATIVE HEART DISEASE (CORONARY SCLEROSIS) DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIO-SCLEROSIS DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs. 10 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from SEPTEMBER 1948 , to JUNE 10, 1956 , that I last saw the deceased alive on JUNE 8, 1956 , and that death occurred at M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Griffin M.D.		ADDRESS (Street, city or town, state) Hughesville, Md. DATE SIGNED 6/11/56	
PHYSICIAN'S NAME (Type) John H. Griffin M.D.		Hughesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/12/56	22c. NAME OF CEMETERY OR CREMATORY St Mary's	22d. LOCATION (City, town, or county) (State) Bryantown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly		ADDRESS Leonardtwn, Md.	
24a. REC'D BY REGISTRAR DATE 6/11/56		24b. REGISTRAR'S SIGNATURE Glenn D. Hauer	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased John A. Jones		Sex Male		Date of Birth June 10, 1915		Place of Birth St. Louis, Mo.	
Usual Residence 1234 N. Broadway, Baltimore, Md.		Cause of Death Heart Disease		Date of Death June 15, 1956		Place of Death Home	
Occupation Teacher		Manner of Death Natural		Time of Death 10:30 AM		Physician's Signature Dr. J. H. Smith	
Signature of Informant John A. Jones		Signature of Physician Dr. J. H. Smith		Signature of Registrar John A. Jones		Signature of Coroner John A. Jones	
Date of Report June 16, 1956		Time of Report 11:00 AM		Place of Report Baltimore, Md.		Signature of Registrar John A. Jones	

BUREAU V. S.

JUN 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **287**

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print!) First PAUL Middle HARRISON Last MASON				4. DATE OF DEATH Month JUNE Day 29 Year 1956			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 26 1889	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HAMPTON MASON				14. MOTHER'S MAIDEN NAME LAURA ANN COALE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 220 34 8327		17. INFORMANT MRS. ALBERTA MASON Address LEONARDTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Aneurysm 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE P. J. BEAN M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) P. J. BEAN M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED June 30 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/2/1956		22c. NAME OF CEMETERY OR CREMATORY OUR LADY'S		22d. LOCATION (City, town, or county) (State) MEDLEY'S NECK MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. CLARKE MATTINGLEY				24a. REC'D BY REGISTRAR June 30 1956 24b. REGISTRAR'S SIGNATURE W. Clarke Mattingley			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUL 5 1956

BUREAU V. S.

Handwritten signature

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6545

CERTIFICATE OF DEATH

06532

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COMPTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. MARYS HOSPITAL		d. STREET ADDRESS RURAL	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle MATHEWS Last MATHEWS		4. DATE OF DEATH Month JUNE Day 8 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH -----1870
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY FARM	
11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES MATHEWS		14. MOTHER'S MAIDEN NAME MARTHA ANTLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records - Leonardtown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Arteriosclerotic CV disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia, left lung.		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1956 , to June 8, 1956 , that I last saw the deceased alive on June 7, 1956 , and that death occurred at 5 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J Roy Guyther M.D.		ADDRESS (Street, city or town, state) Mechanicville DATE SIGNED 6/10/56	
PHYSICIAN'S NAME (Type) J. Roy Guyther, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/12/56	
22c. NAME OF CEMETERY OR CREMATORY Saint Paul Cemetery		22d. LOCATION (City, town, or county) (State) Leonardtown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. B. Robinson		ADDRESS Leonardtown, Md.	
24a. REC'D BY REGISTRAR DATE 6/12/56		24b. REGISTRAR'S SIGNATURE Alan D. Howell	

RECEIVED

J. Roy Gwyther, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6546

CERTIFICATE OF DEATH

06533

Reg. Dist. No. 281

1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 3 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St Mary's Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill	
4. DATE OF DEATH Month June Day 13 Year 1956		d. STREET ADDRESS 4969 Kepplar Road S.E.	
3. NAME OF DECEASED (Type or print) First Raymond Middle A. Last McDonald		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1900
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 16 Days 2 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transportation Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel McDonald		14. MOTHER'S MAIDEN NAME Ella Chester	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT C.R. Bradshaw		Address 1226 Saratoga Ave. N.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 13, 1956 , to June 13, 1956 , that I last saw the deceased alive on June 13, 1956 , and that death occurred at 6:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE P. J. Bean M.D.		DATE SIGNED 6/13/56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-16-56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtown, Md.	
24a. REC'D BY REGISTRAR DATE 6/13/56		24b. REGISTRAR'S SIGNATURE P. J. Bean	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 14 1956	
AGE		SEX	
68		M	
RACE		RELIGION	
W		M	
BIRTHPLACE		RESIDENCE	
MD		BALTIMORE, MD	
OCCUPATION		CAUSE OF DEATH	
RETIRED		HEART DISEASE	
DATE OF BIRTH		PLACE OF BIRTH	
JAN 14 1888		BALTIMORE, MD	
DATE OF DEATH		PLACE OF DEATH	
JAN 14 1956		BALTIMORE, MD	
TIME OF DEATH		HOURS	
10:00 AM		10	
MINUTES		00	
DATE OF BURIAL		PLACE OF BURIAL	
JAN 15 1956		BALTIMORE, MD	
TIME OF BURIAL		HOURS	
11:00 AM		11	
MINUTES		00	
DATE OF INTERMENT		PLACE OF INTERMENT	
JAN 15 1956		BALTIMORE, MD	
TIME OF INTERMENT		HOURS	
11:00 AM		11	
MINUTES		00	

BUREAU A. S.

JAN 14 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06534

Reg. Dist. No. 282

6547

1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Edward Last McGee				4. DATE OF DEATH Month June Day 13 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 19, 1913	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months 4 Days 25 Hours Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Stephen H McGee				14. MOTHER'S MAIDEN NAME Ruth E. Raley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-16-7692		17. INFORMANT Mrs Thelma McGee Hollywood, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin Disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Mechanicsville, Md.				20g. (County) (State)			
21. I certify that I attended the deceased from July 15, 1950 to June 13, 1956 , that I last saw the deceased alive on June 11, 1956 , and that death occurred at 2:15 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Roy Guyther M.D.				DATE SIGNED 6/15/56			
PHYSICIAN'S NAME (Type) Roy Guyther M.D.				Mechanicsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/16/56		22c. NAME OF CEMETERY OR CREMATORY St John's		22d. LOCATION (City, town, or county) (State) Hollywood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly				24a. REC'D BY REGISTRAR DATE 6/19/56			
ADDRESS Leonardtwn, Md.				24b. REGISTRAR'S SIGNATURE Glenn D. Houser			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED William Howard		AGE 45		SEX Male		RACE White	
DATE OF DEATH June 20, 1956		PLACE OF DEATH Home		CITY Boston		STATE Massachusetts	
OCCUPATION Engineer		EDUCATION High School		MARRIAGE Married		RELIGION Roman Catholic	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PERIOD OF ILLNESS 2 weeks		PLACE OF BURIAL Catholic Cemetery	
SIGNATURE OF PHYSICIAN J. J. [Signature]		SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF REGISTRAR [Signature]	
DATE OF SIGNATURE June 20, 1956		DATE OF SIGNATURE June 20, 1956		DATE OF SIGNATURE June 20, 1956		DATE OF SIGNATURE June 20, 1956	

BUREAU V. 1

JUN 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

6548 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

06535

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY ST MARYS MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PALMERS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. MARYS HOSPITAL		d. STREET ADDRESS RURAL	
3. NAME OF DECEASED (Type or print) First LYDIA Middle --- Last PALMER		4. DATE OF DEATH Month June Day 16 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1868
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Faunce		14. MOTHER'S MAIDEN NAME Emma Selby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mary E. Palmer - Palmers, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 782.4 DUE TO Pneumonia - senile Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) open reduction left hip (c) open reduction left hip		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-29-56 , 19 56 , to 6-16 , 19 56 that I last saw the deceased alive on 6-15-56 , 19 56 , and that death occurred at 8 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Michael Barbarich M.D.		ADDRESS (Street, city or town, state) M. B. Barbarich DATE SIGNED	
PHYSICIAN'S NAME (Type) Michael Barbarich		Leonardtwn, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/19/56	
22c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery		22d. LOCATION (City, town, or county) (State) Oakley, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Robinson		ADDRESS Leonardtwn, Md.	
24a. REC'D BY REGISTRAR 6/18/56		24b. REGISTRAR'S SIGNATURE Gerald Houser	

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BUREAU V. S.

1956 67 M12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6549 CERTIFICATE OF DEATH

06536

Reg. Dist. No. 281

1. PLACE OF DEATH a. COUNTY Saint Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural California, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 512 25th. St. South, Arlington, Va.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Station Hospital, USNAS Patuxent River, Maryland				d. STREET ADDRESS Lexington, Maryland			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Russell Lott SEWELL				4. DATE OF DEATH June 1 19 56			
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-17	9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
					Months	Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy				10b. KIND OF BUSINESS OR INDUSTRY Pilot, U.S. Navy		11. BIRTHPLACE (State or foreign country) Alabama	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Will SEWELL				14. MOTHER'S MAIDEN NAME Frances LOTT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 7-28-41		17. INFORMANT U. S. Naval Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basal Skull Fracture 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple depressed fracture ribs, rt. side with probable lung laceration							INTERVAL BETWEEN ONSET AND DEATH 15 Min.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident
20c. TIME OF INJURY Month, Day, Year 6:20 June 1 19 56			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		
20f. (City or town) Near California, St. Mary's			(County) Maryland				
21. I certify that I attended the deceased from 1 June , 19 56 , to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:30 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE C.W. Freeby				ADDRESS (Street, city or town, state) Station Hospital, USNAS			
PHYSICIAN'S NAME (Type) C. W. FREEBY, LT MC USNR				DATE SIGNED Patuxent River, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/5/56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) Arlington, Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson ADDRESS - Leonardtown, Md.				24a. REC'D BY REGISTRAR June 4 1956		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2553

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BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06537

282

6550

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle IGNATIUS Last THOMAS				4. DATE OF DEATH Month JUNE Day 11 Year 1956			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 14 1883	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 5 Days 28 Hours Min. 		IF UNDER 24 HRS. Months Days Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME SAMUEL THOMAS				14. MOTHER'S MAIDEN NAME EMILY CAROLL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT McDOWELL THOMAS Address CALIFORNIA MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 448X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension (c) Generalized Atherosclerosis INTERVAL BETWEEN ONSET AND DEATH 1 year 10 years 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 1 , 19 55 , to June 11 , 19 56 that I last saw the deceased alive on June 11 , 19 56 , and that death occurred at 6 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. H. Patrick				ADDRESS (Street, city or town, state) 323 midway Dr. Lexington Md. DATE SIGNED 6/14/56			
PHYSICIAN'S NAME (Type) W. H. PATRICK M.D.				CALIFORNIA MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/14/1956		22c. NAME OF CEMETERY OR CREMATORY HOLY FACE		22d. LOCATION (City, town, or county) (State) GREAT MILLS MD.	
23. FUNERAL DIRECTOR'S SIGNATURE CHARLES J. MATTINGLY				ADDRESS LEONARDTOWN MD.		24a. REG'D BY REGISTRAR 6/14/56 24b. REGISTRAR'S SIGNATURE Glean D. Houser	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1921		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
1000	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
...		
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
...		

BUREAU V. 3

JUN 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6551

CERTIFICATE OF DEATH

Reg. Dist. No.

06538

282

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Alachua</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u>		c. LENGTH OF STAY IN 1b <u>5 months</u>	
d. NAME OF HOSPITAL (If death in hospital, give full name, address) OR INSTITUTION <u>Station Hospital, USNAS, Patuxent River, Maryland</u>		e. STREET ADDRESS <u>513 SW 8th Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Lorenza</u> Last <u>WILLIAMS</u>		4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negroid</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-24-37</u>
9. AGE (In years last birthday) yrs. <u>19</u>		IF UNDER 1 YEAR Months <u>14</u> Days <u>19</u> Hours <u>56</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Archie Williams</u>		14. MOTHER'S MAIDEN NAME <u>Loureatha Louise Mitchell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>9-22-55</u>		16. SOCIAL SECURITY NO. <u>U. S. Naval Records</u>	
17. INFORMANT <u>U. S. Naval Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>929.8</u> (c) <u>329.8</u> DUE TO (b) <u>329.8</u> (c) <u>329.8</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>While swimming, enlisted beach, USNAS, Patuxent River, Md.</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>While swimming, enlisted beach, USNAS, Patuxent River, Md.</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:17</u> o. m. <u>June 13</u> <u>1956</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Enlisted Beach</u>		20f. (City or town) (County) (State) <u>Lexington Park, St. Mary's, Md.</u>	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>dead</u> _____, 19____, and that death occurred at <u>1:00 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. W. FREEBY, LT MC USN</u>		DATE SIGNED <u>14 June 1956</u>	
PHYSICIAN'S NAME (Type) <u>C. W. FREEBY, LT MC USN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>		22b. DATE THEREOF <u>6/16/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Leonardtwn, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Gainesville, Florida</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. B. Robinson</u>		24a. REC'D BY REGISTRAR <u>6/18/56</u>	
ADDRESS <u>Leonardtwn, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Glean D. Hauer</u>	

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U.S. BUREAU

1955 OCT 14

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6552 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **282**

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLEY		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLEY								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RURAL				d. STREET ADDRESS RURAL								
3. NAME OF DECEASED (Type or print) First AGNES Middle PEARL Last WOOD				4. DATE OF DEATH Month JUNE Day 16 Year 1956								
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>								
8. DATE OF BIRTH JAN. 17, 1903		9. AGE (In years last birthday) 53 yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.			
IF UNDER 1 YEAR	IF UNDER 24 HRS.											
Months	Days											
Hours	Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) MARYLAND								
12. CITIZEN OF WHAT COUNTRY? USA												
13. FATHER'S NAME JOHN H. RUSSELL				14. MOTHER'S MAIDEN NAME SARAH F. HAYDEN								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) -----		17. INFORMANT THOMAS L. WOOD * OAKLEY, Md.								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUNSHOT WOUND - BRAIN 976x DUE TO </td> <td rowspan="3" style="padding: 5px; vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH IMMEJ </td> </tr> <tr> <td colspan="2" style="padding: 5px;"> Conditions, if any, which gave rise to immediate cause (b) DUE TO </td> </tr> <tr> <td colspan="2" style="padding: 5px;"> (c), stating the underlying cause lost. DUE TO </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUNSHOT WOUND - BRAIN 976x DUE TO		INTERVAL BETWEEN ONSET AND DEATH IMMEJ	Conditions, if any, which gave rise to immediate cause (b) DUE TO		(c), stating the underlying cause lost. DUE TO	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUNSHOT WOUND - BRAIN 976x DUE TO		INTERVAL BETWEEN ONSET AND DEATH IMMEJ										
Conditions, if any, which gave rise to immediate cause (b) DUE TO												
(c), stating the underlying cause lost. DUE TO												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SELF INFLICTED GUNSHOT WOUND										
20c. TIME OF INJURY Month, Day, Year Hour 9 a. m. JUNE 16, 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ST MARY'S Co MD								
20f. (City or town) (County) (State) ST MARY'S Co MD												
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE J. Roy Guyther		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										
EXAMINER'S NAME (Type) J. ROY GUYTHER MD		DATE SIGNED June 16, 1956										
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/20/56		22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY								
22d. LOCATION (City, town, or county) BUSHWOOD, Md.		22e. (State)										
23. FUNERAL DIRECTOR'S SIGNATURE G. B. Robinson		ADDRESS - LEONARDTOWN, Md.		24a. REC'D BY REGISTRAR DATE 6/18/56								
24b. REGISTRAR'S SIGNATURE Alfred A. Houser												

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay, the certificate should be written "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. The Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

